Attachment D

Modernizing Michigan Medicaid Waiver Proposal Comments

The following is a compilation of the questions and comments received by the Department of Community Health related to the section 1115 "Modernizing Michigan Medicaid" waiver proposal. These comments were provided during the public forum held on May 4, 2005 and through the MMM Waiver e-mail box. Details that are unavailable at this time will be provided with opportunity for further comment during the public comment period of the policy promulgation process.

Questions	Responses
Prescriptions	
1. Is a 90-day prescription for maintenance medications considered one or three scripts under the waiver?	A 90-day prescription for maintenance meds is considered one prescription. Prescription drugs identified as maintenance medications on the Department's PBM website (www.michigan.fhsc.com) will be recognized as such under this waiver.
2. What is the rationale in limiting prescriptions to four a month?	A prescription drug monthly maximum was developed as a cost-savings measure while maintaining the benefit.
3. How will the proposed cap on prescriptions impact medications with prior authorization?	Even though a medication may have previously received prior authorization, the four-prescription limit will be imposed.
4. Will the managed care carved out drugs (e.g. HIV and anti-psychotics) be included in the four-prescription limit?	Yes.
Managed Care Regulations	
1. How can the Medicaid Health Plans (MHPs) offer a limited benefit package under the current HMO regulations?	The Office of Financial and Insurance Services (OFIS) has rendered an opinion to DCH stating that HMOs are permitted to provide a limited benefit package for Medicaid beneficiaries.
Eligibility and Enrollment	
1. Currently, the only low-income health assistance available to individuals with income from 150-200% of Federal Poverty Level (FPL) is through County Health Plans in the counties that offer this type of program. Will the state find a way to implement a sliding-scale plan for these low-income working adults?	There are currently no plans for eligibility expansion to this age group under this waiver.
2. What groups of persons will have additional coverage under this waiver proposal?	There is no additional expansion planned under the MMM waiver. Program eligibility will expand to the extent that the program can afford to provide benefits for the projected 70,000 individuals that will become eligible annually under the existing criteria.
3. Given the previous lawsuit against the state relative to the caretaker relative benefit, why does the state think it will be successful this time around?	The state is asking for benefit changes that will be applied to optional populations versus elimination of the coverage group.
4. What program types of the 19 and 20-year-olds will be targeted for elimination?	There will be an eligibility freeze on the under 21 aid category, Program Q, scope 2. The freeze will apply only to 19 and 20-year-olds who are in this group. Department wards and Title IV-E are not impacted by the enrollment freeze.

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Questions	Responses
Managed Care Enrollment	
1. Would this waiver remove 19 and 20-year-old pregnant women from the MHPs?	This waiver is not applicable to pregnant women, so the current rules for pregnant women and managed care would continue to apply.
2. Please identify the number of individuals per MHP that will be impacted by the reduction proposal.	The number of persons impacted by benefit restrictions is 60,000, of which nearly 75% are enrolled in managed care. MHP specific numbers will be shared directly with the respective MHPs.
Federally Mandated Rate Methodology	
1. If the waiver of actuarial sound rates is granted, it is likely the MHPs will reduce coverage and deny access. Has the state figured out how to protect beneficiaries?	There should be no denial of access to care or benefit reduction as a result of this waiver aside from the services identified in the waiver proposal. Beneficiaries who are denied benefits by a MHP have the right to file a grievance with the respective health plan and/or file a request for an administrative hearing with the Department's Administrative Tribunal.
Hospital Benefit Limitations	
1. When does the one-year period for the 20-day limit begin? Does the year period relate to the calendar year, the state fiscal year, the beneficiary's eligibility year, or a period in which a patient is initially hospitalized?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
2. Are psychiatric hospitalizations exempt from the 20-day limit?	Psychiatric inpatient hospitalizations are exempt from the limit because of a separate funding source.
3. What is the reimbursement for a partially covered hospitalization? For example, if a patient has a 15-day stay followed by a 10-day stay, will a portion of the second day be covered or will a full DRG payment be made for the second hospitalization.	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
4. Will hospitals be able to bill Medicaid beneficiaries for the uncovered hospital days?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
5. Are physician services provided in the hospital covered beyond the 20-day limit?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
6. Will the 20-day limit be applied based upon date of service, or upon date of invoice. For example, if a patient has two admissions, the first a 20-day stay and then a 10-day stay, and the claim for the second admission is received before the first, how will the 20-day limit be applied? We oppose any situation in which a paid claim is recovered, but are concerned about missing out on reimbursement for a more complicated case because a second, easier to bill claim gets submitted and paid promptly. We also believe that it is inappropriate to create the potential for manipulating reimbursement by pending or holding certain claims in order to use up the 20 day limit on less costly claims.	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
8. Will non-covered days be included in the methodology for capital payments to hospitals?	No.

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9. In the event that an entire hospital stay will not be covered, we anticipate that the hospital will submit a claim to Medicaid for processing with $0 payment. For purposes of determining hospital GME payments, how will the Department treat those claims since the Medicaid GME payment formula includes calculation of case mix index. In a similar vein, how will these cases be handled for Medicaid disproportionate share and rebasing purposes?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
Due Process	
1. What process will be used to notify and give hearing rights to under 21 & Group 2 Caretaker Relative beneficiaries whose benefits will be cut under the waiver? What process will be used to ensure that these beneficiaries are reviewed for potential eligibility under the other eligibility categories that provide full benefits for them?	Each beneficiary will be given notice and provided rights in compliance with federal regulations at 42 CFR 431.200 et. sec. Any process developed will meet any and all requirements in the federal regulations.
Retroactive Enrollment	
1. If a potential Medicaid applicant experiences a catastrophic illness, and the illness is not confirmed for one to three months, would there be a process for special consideration to allow three months retroactive enrollment?	No special considerations have been discussed at this point.
2. Is there a process to ensure that Medicaid applications are processed for the month they are received (e.g. application received on Friday the 28th of the month)?	If the application is received and registered by the Department of Human Services on any day of a given month, eligibility will be made retroactive to the first day of that month.
3. Would the state consider granting eligibility using a specific number of days prior to application rather than using the beginning of the month? It would be impossible for providers to submit full applications for beneficiaries that receive services toward the end of the month.	The state plans to use the first day of the month in which the application is registered. Medicaid enrollment can only be implemented in full month increments. A minimal amount of information is required to register a case with the Department of Human Services.
4. Will retroactivity be available to pregnant women?	The retroactive enrollment change would apply to the entire Medicaid population.
5. How will the enrollment process work when a beneficiary eligible for waiver services becomes eligible for full Medicaid coverage? How will fee for service providers be reimbursed?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
6. How will the Department notify providers of limited or non-covered waiver benefits under the fee-for-service and managed care scenarios if retroactive coverage occurs?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
7. Can beneficiaries convert from full Medicaid coverage to the limited benefit waiver coverage in a retroactive manner?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
8. What is the payment policy for providers that provide services to a patient when the MSA system reflects full Medicaid eligibility and the patient is later determined to have only limited benefits under the waiver?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.

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9. If a patient is supposedly retroactively eligible to the first day of the month, it is unclear what the trigger date is to determine retroactive eligibility. Is it the admission date, the application date, or the date the application is logged in the local DHS office? We urge the Department to implement a policy that limits retroactive eligibility to 30 days retro from the date of admission as signed by the applicant. This would avoid caseload issues in the local office, time lapse between date of admission and date of application and provide uniform treatment to patients.	Medicaid enrollment can only be implemented in full month increments, so it is necessary to make enrollment effective on the first day of the month.
10. Governor Granholm has stated that proposed changes are not to impact children and the aged and disabled categories of Medicaid eligibility. When retroactive enrollment is terminated, all of these groups will be affected, especially the disabled population. Many times an emergency or catastrophic event leads to hospital admission and Medicaid eligibility. The process for applying for Medicaid because of a disability is a long process. This process will need to occur more quickly if retro enrollment is eliminated. Will denials result in appeals because of patients being unable to obtain medical records quickly enough? There are many consequences that will result in difficulties for the patients and hospitals.	Applicants and beneficiaries will be given notice and provided rights in compliance with federal regulations at 42 CFR 431.200 et. sec. Any process developed will meet any and all requirements in the federal regulations.
11. Will the Department of Human Services increase staff to accommodate the need for more timely eligibility and enrollment processing?	The Department of Community Health is unable to respond to questions related to Department of Human Services staffing.
12. Has the state considered shortening the retroactive period rather than eliminating it completely?	No.
Covered Benefits	
1. Will coverage for 19 & 20-year-olds and Caretaker Relatives be provided through managed care or fee-for-service?	Managed care enrollment requirements will continue as they currently do.
2. How will the state administer the benefit limitations?	Implementation details will be provided and comments accepted during the in the standard policy promulgation process.
3. Why are optional benefits being eliminated through this waiver?	The Medicaid program cannot be sustained in its current form with the funding that is available. The decision to eliminate the selected optional services was made with thought to those services that are most vital to beneficiaries.
4. Please define “all emergency room visits”. Specifically, does this include visits to the emergency room that are not for emergencies and are not billed as an emergency room visit?	Co-pay will apply to all services billed in the emergency department.
5. How will the co-pay for emergency room visits that result in an inpatient admission be treated?	No co-pay will be assessed for emergency department visits terminating in an inpatient stay.
6. Will the Medicaid system require an upgrade to track hospital days? It seems this would result in additional expense. Will hospitals know in advance the number of days available to treat a patient?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.

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Questions	Responses
Miscellaneous Questions	
1. What response has MDCH received from CMS regarding the proposal to waive actuarially sound rates?	Because the waiver has not been submitted to CMS for review, there has been no response from the federal government on this proposal.
2. Are there discussions with CMS regarding block grants?	There have been no discussions with the federal government regarding block grants.
3. Is the Department seeking to introduce managed care concepts to mental health, long-term care and Children's Special Health Care Services (CSHCS)?	Managed care has been an integral part of mental health since the Department received approval of a 1915(b) waiver in the late 1990s. Managed care pilots were implemented in the late 90s and then were phased out of the CSHCS program in 2004 due to administrative workload and cost concerns. The concept of managed care in the long-term-care setting has been explored by the current Long Term Care Task Force and will be addressed in its report.
4. How will the Medicare Part D impact Medicaid budget?	The "clawback" provision of the Medicare Modernization Act (MMA) passed by Congress requires that states send money to the federal government to provide funding support for coverage of the dual eligible population (Medicare-Medicaid) in the new Medicare Part D pharmacy benefit. Instead of saving the state money, current estimates indicate Michigan will spend significantly more in clawback and wrap-around (approximately $25.5 million) for Part D than it would have in the absence of the Medicare legislation. The state will lose the savings it has realized for this population through the aggressive rebate and volume purchasing programs Michigan has initiated for its pharmacy programs.
5. Are there discussions with Blue Cross Blue Shield of Michigan to take over any services for Medicaid?	No.
6. If state revenues remain flat while Medicaid caseloads and costs continue to increase, will Medicaid examine the cost savings that home and community based care could provide rather than costly nursing home services?	The Governor's Long Term Care Task Force is currently examining the long-term care system in this state and recommendations to the Governor related to this issue are forthcoming.
7. Has the state considered across the board cuts above 4% so as to not implement changes in eligibility that would hurt certain groups of eligibles?	Numerous options were considered in developing the budget. However the combination of eligibility changes, rate cuts, and federally mandated rate methodology modifications were determined to be the appropriate course to pursue at this time.
8. Has a lottery to support health care in Michigan been considered?	No.
9. What is plan B if the waiver is not approved for implementation by October 1 or not at all?	No alternative plan has been proposed at this time. The DCH budget is subject to legislative approval and the waiver proposal is derived from the executive budget proposed for fiscal year 2006.

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Comments

The following comments related to the MMM waiver document were submitted by various stakeholders. All comments were taken under advisement and will be considered by the Department as the waiver process continues.

1. **Federally Mandated Rate Methodology:**

   - Comments were submitted by several entities related to the proposed waiver of the federally mandated rate methodology for capitation rates paid to the Medicaid Health Plans (MHPs). Of primary concern is the financial viability of the MHPs, particularly those that have recently undergone a rehabilitation process in order to contract with the state in the last re-bid cycle. There is additional concern that access to and quality of services would suffer because of reduced capacity in the provider networks.
   - Hospitals have expressed dissatisfaction with the potential for reduced rates for the MHPs out of concern that they will see reduced reimbursement from the plans for services provided to Medicaid beneficiaries. There is also a concern for total default on payment from unstable MHPs, leaving the hospitals with complete liability for services provided. Additional hospital commentary included a statement that hospitals will receive reduced rates of reimbursement from MHPs for outpatient services because of the 4% fee for service rate cut, but the MHPs will not have an overall rate cut and will, therefore, benefit from the reduced rate paid to hospitals.
   - One of the Medicaid Health Plans commented that the proposal to suspend actuarial soundness requirements is "dangerous" to all of the health plans. Bids by the plans were made based on ability to provide quality care, an adequate network and actuarially approved solvency. It was stated that with the waiver, the State would be responsible for a program that cannot be certified as actuarially sound and it alters the contract agreed to by the health plans. Inadequate funding will affect the ability of the plans to perform according to the contractual requirements.
   - In 2004, MHPs bid for the right to provide services to Medicaid beneficiaries with the understanding that the capitation rates paid for services would be actuarially sound within a two-year period. Further delay of the rate increase will seriously compromise the financial positions of the MHPs. Business decisions were made during the bidding process based on information provided by the state during that period. If the MHPs found they could not continue to provide coverage under the new circumstances, many beneficiaries would be impacted.
   - A hospital commented that proposal to suspend the federally mandated rate methodology would create a "race to the bottom". This hospital expressed concern that this would result in more insolvencies and write-offs to providers.
   - There is concern that the MHPs that have not separated their commercial and Medicaid business will take action to split the business in the future.

- A hospital stated that two-thirds of Michigan hospitals are losing money and for the state to invoke a policy that will result in additional uncompensated care is "disturbing." The same hospital indicated it would support new revenue to fund the Medicaid program.

2. **Retroactive Enrollment:** The state received several comments regarding a request for waiver of the three-month retroactive enrollment requirement.

   - Hospitals commented that the anticipated savings the state expects to realize is grossly underestimated, and the financial impact on hospitals would be much greater. The hospitals commented that an additional unintended ramification would be the reduction in Medicare disproportionate share payments to the hospitals. There was also concern related to the ability of the Department of Human Services to process cases for patients admitted at the end of a month, particularly on a weekend.
   - The MHPs believe that the elimination of retro enrollment will result in a shift of costs from Medicaid to other payers of care and it will weaken the provider networks for managed care. There is also concern that this provision has the potential of delaying enrollment in the Children's Special Health Care Services program and adding costs to managed care.
   - Advocates have commented that elimination of retroactive enrollment will harm individuals who become disabled and incur large amounts of debt related to medical expenses. There is also concern for individuals losing jobs and for the elderly whose savings are depleted because of health care related debt. Also, unpaid debts may result in providers refusing to provide treatment or maintain care for a beneficiary undergoing treatment.
   - There is concern that elderly and disabled individuals in nursing homes may be involuntarily discharged as a result of no retroactive enrollment.
   - One MHP commented that waiver of the retroactive enrollment requirement will negatively impact relationships with providers, causing disenrollment from the program leading to additional access problems.
   - A comment was received that waiver of retroactive enrollment will cause the most harm for the fragile Medicaid population and result in restricted access to health care. There was also concern that long-term care facilities do not have the resources to absorb the losses that would result from the proposal.
   - Concern was expressed related to patients that present to hospitals claiming to have insurance but the verification process proves they do not. By the time coverage or lack thereof is discovered, it may be too late for the hospital to pursue Medicaid eligibility for these patients.

3. **Enrollment freeze for 19 & 20-year-olds:**

   - Hospitals commented that the enrollment freeze would reduce access to health care and increase uncompensated care.

- A comment was also provided that current state law prohibits the elimination of the medically needy category of eligibility for individuals under age 21.
- Elimination of coverage for 19 & 20-year-olds is bad health policy as it will increase the number of uninsured young adults in the state. This will drive up the cost of health care, as these individuals will not have timely access to medical care that could prevent more costly, hospital-based care for more serious and debilitating health problems.
- Federal Financial Participation (FFP) would end for mental health services for this group, shifting costs to the state.
- One hospital commented that freezing enrollment for 19 & 20-year-olds will add to the number of uninsured in the state, which will "shift more of the state's responsibility to a weakened health care delivery system."

4. **Benefit Limitation**:

- Hospitals expressed concern that limiting the inpatient hospital benefit will result in a reduction of the Medicare disproportionate share payments. If the 20-day limit is imposed, the rules could be written in a manner that would maintain Medicaid eligibility for all the days, thereby protecting the DSH funding. For example, if the state paid a per diem amount for days in excess of the 20-day limit, the vast majority of the savings could still be achieved, but the Medicare DSH days, and Medicare DSH funding for hospitals would be preserved.
- One MHP commented that the proposed benefit limitations would be difficult to administer. Because the health plans reimburse hospitals on a DRG basis, it will be difficult to determine reimbursement rates if admissions exceed the limit. The same plan commented that the prescription limitation would potentiate noncompliance with treatment plans, an issue health plans have aggressively been addressing. Further, the benefit limitations were not included in the rate methodology when health plan rates were determined. There is concern for how this would be addressed and how it will impact rates on other populations not included in the limitations.
- Patients who need more than four prescriptions per month may end up in the emergency room. This will end up costing the state more in emergency room care than it would in the original cost of prescriptions.

5. **Emergency Room (ER) Co-payment**:

- A waiver to impose a $10 ER co-payment on all emergency room visits violates federal law at 42 USC 1396o(a)(3). By law, the ER co-payments cannot exceed $6.00. The state cannot establish that non-emergency services are available and accessible to Medicaid beneficiaries in all parts of the state, and the state is unable to pay fee-for-service rates that would be adequate to assure that primary care is available within 30 miles of a beneficiary's home.

6. **Due Process/Notice and Appeal Rights:**

- The Department must provide opportunity to the caretaker relatives and 19 & 20-year-olds to have their eligibility for other categories of Medicaid reviewed before coverage is reduced. If eligibility for other categories is not established, beneficiaries must be given adequate notice and an opportunity for an administrative hearing, as well as time to seek medical advice, prior to benefit reduction.
- The Department should provide notice to beneficiaries not qualifying in another category of coverage. The Department should work with the medical community to identify the information that should be provided to individuals who lose coverage or have new benefit limitations imposed to reduce harm to the beneficiaries' health and welfare.
- The Department should develop materials to educate providers about the benefit changes for some Medicaid beneficiaries in order to make appropriate choices and recommendations in treatment.
- The Department should work with advocates to develop notices to new applicants determined eligible in a medically needy category of coverage to ensure they understand they have been denied coverage in other categories. Also it is important they are informed of the right to appeal the decision and to request eligibility in another category if circumstances change. The Department should work with DHS so that staff is made aware of the new coverage limitations so that eligibility for other categories will be checked.

7. **General Comments:** The following bullets summarize/paraphrase general comments received from various entities regarding multiple issues related to the waiver proposal:

   - Increasing the number of underinsured adults in Michigan undermines health policy objectives. Arbitrary limits on benefits, such as those proposed for prescription drugs and hospital days, will prevent beneficiaries from obtaining the services their physicians prescribe. Because the Department has taken other steps to address utilization issues with managed care and prior authorization requirements, the waiver restrictions will impact individuals with the greatest needs. Because these individuals will be considered "insured" by Medicaid, they will be unable to qualify for pharmaceutical company discount programs to obtain prescription drugs not covered because of the benefit limit.
   - Arbitrary limits will temporarily reduce costs but lead to undesirable outcomes.
   - Limiting prescription drugs will discourage the use of the most cost effective treatment for some conditions, and the number of avoidable hospitalizations will increase.
   - Limiting benefits for parents and caretaker relatives undermines human services policy objectives. The reduced benefit package may result in deteriorating health for these caretakers which in turn could result in their inability to continue in their roles as caretakers with the children forced into foster care. Many parents affected by the proposed cuts may not be able to continue employment if they are unable to access medical care. Therefore, cutting Medicaid services

may force these individuals back to the welfare rolls, increasing the Department of Human Services caseload.
- Family stability may be adversely impacted as the result of benefit cuts.
- The Department should work with advocates and providers to develop protections that will assure continuity of care for beneficiaries with unpaid medical bills as a result of waiver changes. This is especially important for individuals in nursing homes.
- The state budget is being balanced at the expense of Michigan's hospitals and the vulnerable populations they serve.
- One MHP expressed the opinion that the financial impact of the waiver proposal on the federal government is unclear and the ability of the state to assess the proposal's success is not evident.
- The waiver proposal "does not modernize Medicaid; rather it ushers in substantial program cuts in eligibility, coverage and payment."
- Michigan's Medicaid program is under funded and this waiver proposal will exacerbate the problem.
- The state provided inadequate opportunity for public comment.
- Not enough implementation and operational details have been made available to adequately assess the impact on hospitals making it difficult to calculate the financial impact the waiver might have. There is particular concern in this regard related to the request for a waiver of retroactive enrollment.
- A comment received from the general public indicated a concern for the indigent and the nursing home and hospital industries if the waiver proposal were to be implemented.

8. **Recommendations:** The Michigan Association of Health Plans and its constituents have proposed the following recommendations in lieu of the proposed waiver components:

   - "The Medicaid Program should implement a series of policy and contract changes that will not only assure that the capitation rates paid to Medicaid health plans are actuarially sound, as required under federal regulations, but can extend the demonstrated cost savings to other areas of the state budget." To accomplish this recommendation, it is proposed that the state should change the underlying assumptions for the health plan rates. Proposed options include:
     - Benefit/coverage modifications similar to other product lines and other state programs;
     - Administrative, contract and policy changes that can reduce the underlying administrative requirements for managed care;
     - Reimbursement policy changes that can affect both the Medicaid fee-for-service program and managed care;
     - Incorporating additional features to the managed care program and benefiting through the HMO assessment used to underwrite Medicaid services; and

  - Extending managed care concepts of competition, best practices, evidence-based medicine, and outcome-based services elsewhere in health care services supported in different program areas of the state budget.

- "Assure that any future Medicaid fee-for-service provider rate increases are built into the rates paid to Medicaid health plans in order to have the Medicaid managed care program remain actuarially sound." Because Medicaid health plans are required to reimburse fee-for-service rates to out-of-network providers, health plans have experienced rate creep. To address this issue, it was proposed that the Michigan Association of Health Plans work with the Administration and the legislature to develop a formula addressing the issue. It was also suggested that Medicaid policy changes and/or changes to the health plan contract could be made to exempt health plans from paying fee-for-service rates that change during a contract period.
- "Continued collaboration on efforts to reduce Medicaid emergency department utilization of non-emergent services and develop and implement incentives for services to be provided in alternative settings."
- "Full implementation of electronic billing and communication in the Medicaid program for all payers and providers." The MAHP has suggested that expansion of electronic billing will achieve financial savings for the Medicaid program and that permission to require electronic billing be sought.
- "Ongoing identification and implementation of cost avoidance opportunities through revision of contract administrative requirements or change in DCH operations and expansion of the concept of "deeming" that would accept national accreditation as compliance with the same or similar state requirements." The MAHP states that unnecessary regulatory requirements result in additional costs that could be redirected to sustain services if the requirements were eliminated.